Sandy Valley Elementary School
Little Cardinal Preschool
5018 State Route 183
Magnolia, Ohio 44643
(330) 866-9225

"Where students EARN an education, LEARN to be successful, and YEARN to be the leaders of tomorrow."

STUDENT ENROLLMENT FORM

STUDENT INFO

Student's Legal Name: ____ **Sex: M F**

Last *First* *Middle*

Address: ____

Street *PO Box #* *City* *State* *Zip Code*

DOB: ____________ **City/Country of Birth:** ______________________ **SS#:** ____________

City of Birth *Country of Birth*

County of Residence ______________________ **IEP:** Yes ___ ; No ___ **ELL:** Yes ___ ; No ___

PREVIOUS PRESCHOOL ATTENDED:

Name: ______________________ **City:** ______________ **State:** ____________

ETHNICITY:

White/Caucasian: ___ ***Black/African American:*** ___ ***Hispanic/Latino*** ___ ***Asian:*** ___ ***American/Native Alaskan:*** ___

Native Hawaiian or other Pacific Islander: ___ *(Hawaii, Guam Samoa, or other Pacific Islands)*

FAMILY:

Child lives with: Both Parents ___; Mother ___; Father ___; Grandparent ___; Guardian ___; Other ___

	Mother	Father
First & Last Name	*First* *Maiden* *Last*	*First* *Last*
Foster Parent/Guardian	*First* *Last*	*First* Last
Address:		
Home Phone:		
Cell Phone:		
Work Phone:		
Employed by:		
E- Mail Address:		

CUSTODY:

Is the child affected by any court order regarding custody? Yes ___ No ___

Is a copy of the most recent custody agreement on file in the school office? Yes ___ No ___

Person/s with Legal Custody of Child: ______________________

Relationship of person/s with Legal Custody:

OVER ⇨

SIBLINGS:

Name	*Age*	*Grade*

EMERGENCY CONTACTS

People to contact in the event of an emergency if parent cannot be contacted. (Please use two (2) different households).

Name: ______	Name: ______
Street Address: ______	Street Address: ______
City/State/Zip Code: ______	City/State/Zip Code: ______
Relationship to Child/Phone # ______	Relationship to Child/Phone # ______
Name of Physician or Clinic: ______	Name of Physician or Clinic: ______
Street Address: ______	Street Address: ______
City/State/ Zip Code: ______	City/State/Zip Code ______
Phone # ______	Phone # ______

PARENT AUTHORIZATION FOR RELEASE OF CHILD TO SECOND PARTY:

Below are listed the names of *AT LEAST THREE* parties to whom your child may be released.

(Under NO circumstances will the child be released to anyone not known to the school without authorization from parents or guardian).

Persons AUTHORIZED to pick up child:

My child may be released to:

Name: ______ Relationship: ______

Address: ______ Phone No. ______

Parent Signature: ______ Date: ______

My child may be released to:

Name: ______ Relationship: ______

Address: ______ Phone No. ______

Parent Signature: ______ Date: ______

My child may be released to:

Name: ______ Relationship: ______

Address: ______ Phone No. ______

Parent Signature: ______ Date: ______

NOTE: It is legal for either parent to pick up a child, unless we have a copy of a court order indicating restrictions.

Please provide any restrictions or qualifications to this authorization:

______

Identify Person(s) ***NOT AUTHORIZED*** to visit or pick up your child:

______ ______

Please notify your child's teacher, in writing, if any of the above information must be changed. Your child will not be sent home with anyone not listed on this form without a written, signed, and dated note from the parent. Your child's teacher may ask for a photo ID (Driver's License).

To the best of my knowledge, I certify the above information is true, correct, and complete.

Parent's Signature: ______ Date: ______

HEALTH ALERT ☐

EMERGENCY MEDICAL AUTHORIZATION

PURPOSE – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached. This information may be shared with the educational team to best meet your child's needs.

Student Name____________________ Phone # ____________ Bus # ________

Address____________________ School District ____________________

____________________ School Attending____________________

Address Change Y N Birth Date____________ Sex M F Grade ________ Home Room____________

Residential Parent or Guardian

Mother____________ Day Ph # ____________ Cell # ____________

Email ____________________ Pager # ____________

Father____________ Day Ph # ____________ Cell # ____________

Email ____________________ Pager # ____________

Other Name____________ Day Ph # ____________ Cell # ____________

Name of Relative or Childcare Provider____________________

Address ____________________ Phone # ____________

____________________ Relationship ____________

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor ____________________ Phone # ____________

Dentist ____________________ Phone # ____________

Medical Specialist ____________________ Phone # ____________

Hospital ____________________ Phone # ____________

Below check any current health condition that may require attention during the school day:

☐ Allergies (be specific):

- ☐ Foods____________________
- ☐ Medicines____________________
- ☐☐ Bee Stings____________________
- ☐☐ Other____________________

☐ Asthma

Cancer

Diabetes

☐ Hearing Problems ☐ Hearing Aid(s)

☐ Heart Problems (be specific) ____________________

☐ Surgeries (include year) ____________________

☐ Concussion/head injury-year____________________

☐ Physical disability (be specific) ____________________

☐ Respiratory (be specific) ____________________

☐ Seizures ____________________

☐ Vision problems (be specific) ____________________

☐ Glasses ☐ Contacts

☐ ADD/ADHD

☐ Behavior/emotional problems____________________

☐ Other (be specific) ____________________

List all medications and dosages your child receives on a continual basis:

PLEASE COMPLETE PART I *OR* PART II --- NOT BOTH

Part I – TO GRANT CONSENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed Necessary by the designated physician or dentist, or in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to the designated hospital or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinion of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Date____________________ Parent or Guardian Signature____________________

Part II – REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

____

____

____

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PERMISSION FORM

Annual Parent Roster

As required by the Ohio Department of Education, each year we prepare a roster of each class of children in our program. This roster will NOT be furnished to any persons other than parents of children enrolled in our Early Childhood Program. Please read carefully, check the line that applies, and print the information to be included.

______ I GIVE PERMISSION to have my child's name or information included on the Parent Roster.

______ I DO NOT wish to have my child's name or information included on the Parent Roster.

Photo/Media Permission

______ I GIVE PERMISSION for my child to be photographed or videotaped under the supervision of the school for various media or for instructional purposes as noted below.

- Teacher created student scrapbooks or photo CD's.
- Media purposes (newspapers, annual report, pamphlets, social media)
- Class photo/school yearbook
- Digital prints shared with other families (only when their student is also in the photo)

______ I DO NOT GIVE PERMISSION for my child to be photographed or be videotaped under the supervision of the school for any reason.

Screenings/Observations Permission

______ I GIVE PERMISSION for my child to receive the following screenings in order to collect data or identify and help correct any potential problems before my child begins kindergarten:

- Overall development, basic motor, language, conceptual skills, social/emotional
- Vision
- Hearing and periodic impedance monitoring (tympanometry)
- Speech
- Kindergarten Transition Skills Summary with my child's school district

______ I DO NOT GIVE PERMISSION for my child to be screened.

Parent's Signature ____

Date ____________________

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[ ] SV HS
[ ] SV MS
[ ] SVE
[ ] Saint James

TRANSPORTATION REQUEST

Name: ____

Residential Address: ______________________________________

Street

____

City *State* *Zip Code*

Pick up address if different from above:

____

Street *City*

Drop off address if different from above:

____

Street *City*

Phone: ____________________ Birthdate: ________________ Grade: ____

Entry Date: ______________________ Start Date: ________________

Medical Alert Information ____________________________________

FAX to 330-866-2351

Transportation Department Use Only

Am Bus Assigned ______________ Stop Location ____________________

PM Bus Assigned ______________ Stop Location ____________________

AM Transfer Bus ______________

PM Transfer Bus ______________

Approved By: ____

Doug Neading, Transportation Supervisor

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2021-2022 Student Emergency Plan

In case of an emergency such as maintenance problems, threatening weather, bomb threats, etc, there could be a need for emergency dismissal or early dismissal. In the event of such an emergency, it is impossible to phone all parents for dismissal instructions. In some cases phones may not be inoperable, so phone calls will not be made. An automated All Call will be placed district wide. Therefore, if this event should occur, your child should know where he or she is to go.

Student Name: ________________________________ Date: __________________________

Teacher: _____________________________________ Grade: _________________________

____ Follow usual dismissal (Ride bus home; Parent pick-up; Drive if high school student.

____ Other (*Please complete the following)*

____

Alternate Name

____

Alternate Address *Bus Number*

Parent/Guardian Signature: ____ Date: __________

All students MUST HAVE an "Emergency Plan"

Please inform your child of the *Emergency Early Dismissal Plan.* Make arrangements with a neighbor, close relative, or friend to care for your child if there is an early dismissal. Supply name, address, and a different bus number for the person responsible for your child. If your child is older, instruct how he/she is to get into the house in the event no one is at home. Let your child know where you can be reached once he/she arrives at home. Have them notify you. If you suspect an early dismissal because of bad weather, please listen to the radio stations and TV stations for announcements. WHBC, WJER, Fox 8, News Channels 3 & 5.
Review these instructions regularly with your child.

Ohio Department of Job and Family Services
Ohio Department of Education

Must complete for tuition

EARLY CHILDHOOD EDUCATION ELIGIBILITY SCREENING TOOL

How do I apply for Early Childhood Education Services?	**You will need to:** **1.** Complete the screening tool. **2.** Do not submit to the Ohio Department of Education. **3.** Submit this form to your provider.
How do I apply for Publicly Funded Child Care?	**You will need to:** **1.** Complete the screening tool, JFS 01121. **2.** Complete the JFS 01122 Publicly Funded Child Care Supplemental Application. **3.** Submit both the JFS 01121 and JFS 01122 to your local county agency. **4.** Attach verifications to the JFS 01122 (see verification requirements below).
How do I complete this application?	**1. Fill out this application:** Answer as many questions as you can. **2. Be sure to sign the application.**
When will I receive assistance?	**ECC:** You will be notified by your provider when you may begin care. **Child care:** Eligibility for the child care program is based on the date a signed application is submitted to the county agency. Eligibility for this program is determined within 30 days from the earliest date either the JFS 01121 or JFS 01122 is submitted.
What verifications do I need for publicly funded child care?	**You will need to:** **1. Submit the JFS 01121 and JFS 01122.** **2. Provide proof of income:** Verification of all money coming into your household. (such as pay stubs, tax records, award letters, child support) **3. Proof of any child support paid.** **4. Proof of citizenship or qualified alien status for children in need of care:** If the county agency verifies that a caretaker receives or has received OWF for a child, verification of citizenship is not required. **5. Provide proof of a qualifying activity for all caretakers in the household:** Verification of a qualifying activity includes but is not limited to an official school schedule, work schedule, employment verification, self-sufficiency contract, etc. **6. Provide the name and address of an eligible child care provider chosen for each child in need of care.**
What is Step Up To Quality?	**Step Up To Quality was created to help families identify early learning and development programs that go beyond the minimum standards of licensing. Star Rated programs demonstrate higher levels of quality in a variety of ways. Ask your provider if they are participating.**

Ohio Department of Job and Family Services
Ohio Department of Education

EARLY CHILDHOOD EDUCATION ELIGIBILITY SCREENING TOOL

*This form is valid only for publicly funded child care when attached to a
JFS 01122 Publicly Funded Child Care Supplemental Application

Tell us about you (the applicant)

First Name		Middle Initial	Last Name	
Address			Today's Date	
City	State	County		Zip Code
Phone Number ( )	Additional Phone Number ( )	E-mail Address		

Tell us about the people in your home

Name *(First, Middle, Last)*	**Relationship to You** *(spouse, son, friend, etc.)*	**Race**	**Hispanic or Latino** *Y or N*	**Spoken Language**	**Date of Birth**	**Gender** *M or F*	**U.S. Citizen** *Y or N*
	Self	☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					

Tell us about your needs for your child(ren)

Child 1	Provider Name and Address	Child's Needs	What hours/days do you need services? (i.e. child care or preschool) Check all that apply
Name		Do you have concerns about your child's growth and/or development? ☐ Yes ☐ No Describe: ____________	☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends
Child's Mother's Maiden Name			What is the child's home school district? ____________
Child's City of Birth			

Child 2	Provider Name and Address	Child's Needs	What hours/days do you need services? (child care or preschool) Check all that apply
Name		Do you have concerns about your child's growth and/or development? ☐ Yes ☐ No Describe: ____________	☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends
Child's Mother's Maiden Name			What is the child's home school district? ____________
Child's City of Birth			

Child 3	Provider Name and Address	Child's Needs	What hours/days do you need services? (child care or preschool) Check all that apply
Name		Do you have concerns about your child's growth and/or development? ☐ Yes ☐ No Describe: ____________	☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends
Child's Mother's Maiden Name			What is the child's home school district? ____________
Child's City of Birth			

Tell us about your finances

Will you or the people in your home receive income this month? ☐ Yes ☐ No

Income refers to all the money that you and the people in your home receive such as earnings from employment, child/spousal/medical support, disability benefits, retirement benefits, Workers' Compensation, Social Security, SSI, Veterans Benefits, etc.

If yes, please complete the table below.

Name	Type of Income	Amount of Income *(before taxes)*	How Often Received *(weekly, bi-weekly, etc)*	Date Last Received	Work or School Schedule (please list times)
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____

Do you or anyone in your household pay Child or Spousal Support? ☐ **Yes** ☐ **No**

How Much?

Signature of Applicant	Date

Sandy Valley Local School District
5362 State Route 183 NE,
Magnolia, OH 44643
330-866-3339

Dear Sandy Valley Preschool Parent or Guardian,

In partnership with the Sandy Valley School District, SPARK (Supporting Partnerships to Assure Ready Kids) is a FREE kindergarten readiness program for families who have a **3 or 4 year old** and live in the Sandy Valley School District.

- The SPARK program is **FREE**, provides one on one activities, and is fun for parents and children.
- The SPARK program works with families to **get children ready for kindergarten.**
- SPARK families receive **free books, children's items that encourage learning**, information and individual support.
- SPARK families get connected to **community resources**, if needed.

Families can participate in SPARK even if their child is involved in other programs, such as child care, preschool, or Head Start. SPARK will **ENHANCE**, not replace, other services or programs children are currently receiving.

If you or someone you know would like to participate in SPARK (your child, a family member, a friend, or even a neighbor) complete the form at the bottom of this letter to the school office. You can also contact the SPARK office directly at 330-491-3272.

____________________Please cut and return the information below____________________

Your name or interested parent's name ______________________________

Phone number____________________

Secondary phone number________________________

Your child's name or interested child's name______________________________

Child's date of birth________________________

Preferred method of contact _________call _________text

Best time to contact________________________

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CHILD MEDICAL STATEMENT

Section 1 – Child Medical Information

Child's Name: ______________________ Date of Birth: ________
DATE OF EXAM: ______________________

*** ATTACH A COPY OF THE CHILD'S UPDATED IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS AND EXEMPT IMMUNIZATIONS

Immunizations: circle one			Exempt from Immunization:		
Complete for Age	Yes	No	Religious Conviction	Yes	No
In Process	Yes	No	Health	Yes	No
			Other ______		

Limitations or Health Conditions:

Allergies:

Medications:

Dietary Restrictions (please be specific):

Recommended Assessments/Screenings					
Vision	Yes	No	Lead	Yes	No
Hearing	Yes	No	Hemoglobin	Yes	No
Dental	Yes	No	Other		
Measurements					
Height					
Weight					
BMI					

Section II– Child Medical Statement Verification

This child has been examined and is in suitable condition to participate in group care.
This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code.

Physician/Provider Name: ______________________ **Date:** ________

Physician/Provider Signature: ______________________

Provider Address: ______________________

Phone: ____________ **Fax:** ______________